

CHAPTER 16 – REMITTANCE ADVICE, REIMBURSEMENT, AND COST SHARING

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REFERENCES: A.R.S. § 36-2903.01, A.R.S. § 36-2904; A.A.C.R9-22-703, A.A.C. R9-29-301; Billing Information, AHCCCS Fee-For-Service Provider Manual

General Information

This chapter contains general information related to Division billing rules and requirements. Policies regarding submission and processing of Long Term Care services (LTC) and fee-for-service claims are communicated to providers via such channels as the Provider Billing Manual and Vendor Blasts.

Claims must meet Division requirements for claims submission. In the absence of specific policies, the Division endeavors to follow AHCCCS/Medicare policy guidelines as closely as possible.

The Division includes nationally recognized methodologies to correctly pay claims including, but not limited to:

- A. National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgery Center (ASC) and Outpatient services • Multiple Procedure/Surgical Reductions
- B. Global Day E & M bundling standards.

Claim Submission Requirements

- A. Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or are not submitted on the correct form will be returned to providers without being processed. If a claim is returned, the provider must refile a legible copy of the claim on the correct type of claim form and submit it within the required time frame.
- B. The Division retains a permanent electronic image of all paper claims submitted, in accordance with State retention record requirements, requiring providers to file clear and legible claim forms.
- C. Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") may not be used. Permanent self-adhesive correction tape must be used to cover information that should not appear on the claim.
- D. Documentation is required when resubmitting claims if the documentation was submitted with an earlier version of the claim and the claim number must be referenced on the resubmitted claim.

All paper claims should be mailed, with adequate postage, to:

DDD Business Operations
Attn: Claims Department
Mail Drop 2HC6 P.O. Box 6123
Phoenix, AZ 85005-6123

The Division also accepts Health Insurance Portability and Accountability Act (HIPAA) compliant 837P electronic claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837P transactions. For Electronic Data Interchange (EDI) inquiries, roster issues or to become a Division Trading Partner, please refer to the Companion Document and Transaction Specifications for HIPAA 837P Claim Transactions, found under the Division's Web Site.

Claims and document attachments may also be submitted through the Division on-line claim submission process. For guidance in using the Division SFTP (Secure File Transfer Protocol) site, refer to the Division's Provider Claims Submission Guide.

Claim Submission Time Frames

- A. In accordance with A.R.S § 36-2904 (H), an initial claim, for services provided to a Division recipient, must be received by the Division not later than six months from the date of service, unless the claim involves retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the patient.
- B. Claims initially received beyond the six-month time frame, except claims involving retro-eligibility, will be denied.
- C. If a claim is originally received within the six-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, the Division is not liable for payment.
- D. As defined by A.R.S § 36-2904 (H)(1) a "clean claim" is:

"A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity."

Remittance Advice

Remittance Advice explains the payment and any adjustments made to a payment during the adjudication of claims. The Division supplies a remittance advice document to the provider which provides location code, member ID, member name, service code and description, Provider number, start date, end date, units, rate, payment amount, TPL amount, and claim line ID. The remittance advice includes the formal claim dispute process and correction/resubmission of claims process. See AHCCCS Fee-For-Service Provider Manual Chapter 27 for additional information.

Prior Quarter Coverage Eligible

Effective 1/1/2014, the Division is required to expand the time period the Division pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for the Division, if the individual met the eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

- A. Received one or more Division-covered services during the month and
- B. Would have qualified for the Division at the time services were received if the person had applied for Medicaid.

The Division Administration will determine whether or not an applicant meets prior quarter coverage criteria. If the applicant meets the prior quarter coverage criteria, providers will be required to bill the Division Administration for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the recipient of prior quarter coverage eligibility.

Upon notification of prior quarter coverage eligibility, A.A.C. R9-22-703 requires the provider to promptly refund to the recipient any payments that have been received for services in an approved prior quarter period and must accept payment by the Division as payment in full.

Providers failing to reimburse a recipient for any payments made by the recipient will be referred to the DES Office of Inspector General (OIG) for investigation and action.

For covered services received during the prior quarter which have not yet been reimbursed or billed the provider must submit a claim to the Division Administration.

Division Managed Care Contractors are not responsible for determining prior quarter coverage or for payment for covered services received during the prior quarter. Claims submitted to Division Managed Care Contractors for prior quarter coverage will be denied.

- A. Providers may submit prior quarter coverage claims for payment to the Division in one of the following ways:
- B. The HIPAA compliant 837 transaction, or
- C. Through the Division on-line claim submission process, or
- D. By submitting a paper claim form.

All providers, including Regional Behavioral Health Authority (RBHA) and Tribal Regional Behavioral Health Authority (TRBHA) providers must submit a claim directly to the Division Administration. Pharmacy point of sale claims must be submitted to the Pharmacy Benefits Manager, Med Impact.

Hospital Presumptive Eligibility (HPE)

Recipients eligible under HPE where providers are billing for prenatal services should bill the Division Fee for Service program for prenatal visits, utilizing the appropriate Evaluation and Management (E&M) code, performed during the HPE period. Global obstetric (OB) billing for total OB care is only applicable for the plan in effect on the date of delivery and is only applied if global delivery guidelines are met (i.e., 5 or more visits performed while member is eligible under the plan). If guidelines are not met services should be billed as Fee for Service.

Retro-Eligibility

Retro-eligibility affects a claim when no eligibility was entered in the Division system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

Fee-for-service claims are considered timely if the initial claim is received by the Division not later than six months from the Division date of eligibility posting. Claims must attain clean claim status no later than 12 months from the Division date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the date of eligibility posting. This time limit does not apply to adjustments which would decrease the original Division payment due to collections from third party payers.

Billing Division Recipients

Arizona Revised Statute § 36-2903.01(K) prohibits providers from billing the Division recipients, including Qualified AHCCCS/Medicare Beneficiary (QMB) Only recipients, for Division-covered services:

Note: "QMB Only" is a Qualified AHCCCS/Medicare Beneficiary under the federal program but does not qualify for Medicaid. Under A.A.C. R9-29-301, the Division shall only reimburse the provider for the Medicare deductible/copay/coinsurance amount when Medicare pays first.

Upon oral or written notice from the patient that the patient believes the claims to be covered by the system [Division], a contracted or non-contracted provider of health and medical services described in A.R.S. §36-2907 shall not do either of the following unless the provider has verified through the Division Administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:

- A. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
- B. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care

or services unless specifically authorized by this article or rules adopted pursuant to this article.

Resubmissions, Replacements, and Voids

The Division Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to the provider on the Division Remittance Advice/Billing Detail Report. The provider should correct claim errors and resubmit claims to the Division for processing within the 12-month clean claim time frame as defined by A.R.S. § 36-2904 (H)(1) a "clean claim".

When resubmitting a corrected claim when the original claim was denied or partially denied, the provider must:

- A. For a Home and Community Based Services (HCBS) claim, resubmit to the SFTP site a new billing template for all the provider's denied claims with the appropriate corrections.
- B. For a Fee For Service (FFS) denied claim:
 - 1. Submit a new claim form containing all previously submitted lines. The original Division Claim Reference Number (CRN) must be included on the claim to enable the Division system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.
 - 2. Resubmit any documentation that was sent with the denied claim.
- C. To resubmit a denied Centers for Medicare and Medicaid Services (CMS) 1500 (Professional) claim:

Enter "A" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim in the field labeled "Original Ref. No." Failure to resubmit a 1500 claim without Field 22 completed will cause the claim to be considered a "new" claim and will not link to the original denial. The "new" claim may be denied for timely filing exceeded.

Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example:

The provider submits a three-line claim to the Division. Lines 1 and 3 are paid, but Line 2 is denied.

When resubmitting the claim, the provider should resubmit all three lines. If only Line 2 is resubmitted, the Division system will recoup payment for Lines 1 and 3.

D. To resubmit a denied Uniform Billing (UB)-04 (Hospital) claim:

Resubmit the UB-04 with the appropriate Bill Type: xx7 for resubmission and corrected claim. Failure to resubmit a UB-04 without the appropriate Bill Type will cause the claim to be considered a "new" claim and will not link to the original denial. The "new" claim may be denied for timely filing exceeded.

1. Write the CRN of the denied claim in the "Remarks" (Field 64).
2. If Field 64 is used for other purposes, write the word "Resubmission" and the CRN at the top of the claim form.

E. To resubmit a denied American Dental Association (ADA) claim enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number). Failure to resubmit an ADA claim without Field 2 completed will cause the claim to be considered a "new" claim and will not link to the original denial. The "new" claim may be denied for timely filing exceeded.

After a claim has been paid by the Division, errors may be discovered in the amounts or services that were billed. These errors may require submission of a replacement to the paid claim. For example, the provider may discover that additional services should be billed for a service span or that incorrect charges were entered on a claim paid by the Division.

For FFS/acute claims, if the claim was submitted via a Manual Claim form (CMS 1500 or UB-04), providers are required to resubmit a corrected claim form while referring to the original CRN the claim was issued payment on. A difference of payment may be issued based on the review of the received documentation.

For LTC claims, errors may require submission of required documentation in order to adjust specific claim lines in Focus for rebilling and payment purposes. This process is called Reversal (Adjustment). In order for the Division to process a Reversal/Replace request, the provider should contact the DDD Customer Service Center at 1-866-2295553. After receiving the request, specific documentation will be emailed to the provider, which should be completed by the provider and submitted back to the Division. The processing of this request may take 3 to 4 weeks. Providers will receive an email notification once the Reversal has been completed and when the corrected billing has processed. Providers can refer to the original Bill ID, Billing Detail Report for verification of the Reversal process and can also review the Check Detailed Report for further verification.

When adjusting a paid claim, the provider must submit a new claim replacement containing all previously submitted lines. If any previously paid lines are blanked out, the Division system will assume that those lines should not be considered for reimbursement, and payment will be recouped. The provider must attach any documentation that was sent with the original paid claim.

The original CRN must be included on the replacement claim to enable the Division system to identify the claim to be adjusted. Otherwise, the claim will be entered

as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Every field can be changed on the replacement claim except the service and billing provider ID number and tax ID number. If these must be changed, the provider must void the claim and submit a new claim.

F. To replace a paid CMS 1500 claim:

1. Enter "A" in Field 22 and the CRN of the claim to be adjusted in the field labeled "Original Ref. No." Failure to submit a replacement 1500 claim without Field 22 completed will cause the claim to be considered a "new" claim and will not link to the original claim. The "new" claim may be denied for timely filing exceeded.
2. Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example 1:

The provider submits a three-line claim to the Division. All three lines are paid.

The provider discover an error in the number of units billed on Line 3 and submit an adjustment.

When submitting the adjustment, the provider must resubmit all three lines. If only Line 3 is resubmitted, the Division system will recoup payment for Lines 1 and 2.

An adjustment for additional charges to a paid claim must include all charges -- the original billed charges plus additional charges.

Example 2:

The provider bills for two units of a service with a unit charge of \$50.00 and are reimbursed \$100.00. After receiving payment, the provider discovers that three units of the service should have been billed.

When adjusting the claim, the provider bills for three units and total billed charges of \$150.00 (3 units X \$50.00/unit). The Division system will pay the claim as follows:

Allowed Amount (3 units)	\$150.00
Previously Paid to Provider	<\$100.00>
Reimbursement	\$50.00

If the provider billed for the one additional unit at \$50.00, the Division system would recoup \$50.00 as shown below:

Allowed Amount (1 unit)	\$50.00
Previously Paid to Provider	<\$100.00>
Reimbursement (Amount recouped)	<\$ 50.00>

G. To replace a paid UB-04 claim:

1. Resubmit the UB-04 with the appropriate Bill Type: xx7 for resubmission and corrected claim. Failure to replace a UB-04 without the appropriate Bill Type will cause the claim to be considered a "new" claim and will not link to the original denial. The "new" claim may be denied for timely filing exceeded.
2. Write the CRN of the claim to be adjusted in the "Remarks" field (Field 80).
3. If Field 80 is used for other purposes, write the word "Adjustment" and CRN at the top of the claim form.

H. To replace a paid ADA claim:

1. Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number). Failure to replace an ADA claim without Field 2 completed will cause the claim to be considered a "new" claim and will not link to the original denial. The "new" claim may be denied for timely filing exceeded.
2. When voiding a claim, the provider should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.
3. Unlike resubmissions and adjustments, the provider should submit only the line(s) to be voided. Lines that should not be voided should be blanked out to avoid recoupment of payment for those lines.

I. To void a paid CMS 1500 claim enter "V" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

- J. To void a paid UB-04 claim:
1. Use bill type xx8.
 2. Enter the CRN of the claim to be voided in the "Remarks" field (Field 80).
 3. If Field 80 is used for other purposes, write the CRN at the top of the claim form.
- K. To void a paid ADA claim write the word "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

Overpayments

A provider must notify the Division of an overpayment on a claim by submitting an adjustment to the paid claim. Providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

The claim will appear on the Remittance Advice/Billing detail report showing the original allowed amount and the new (adjusted) allowed amount.

Do NOT send a check for the overpayment amount, unless instructed by the claims unit.

The claim must be adjusted and the overpaid amount will be recouped.

General Division Billing Rules

Most of the rules for billing the Division are outlined in the Division's Provider Policy Manual Chapter 12, Billing and Encounter Submission, and are observed by AHCCCS, Medicare and other third party payers.

- A. Medicare and Third Party Payments
1. By law, the Division has liability for payment of benefits after all other third Party payers, including Medicare.
 2. The provider must determine the extent of third party coverage and bill all third party payers prior to billing the Division.
- Note: Refer to Provider Policy Manual Chapter 57, Third Party Liability.
- B. Age, Gender and Frequency-based Service limitations
1. The Division imposes some limitations on services based on recipient age and/or gender.
 2. Some procedures have a limit on the number of units that can be provided to a recipient during a given time span.
 3. The Division may revise these limits as appropriate.

All claims are considered non-emergent and subject to applicable prior authorization requirements unless the provider clearly identifies the service billed on the claim form as an emergency.

On the UB-04 claim form, the Admit Type (Field 19) must be "1" (emergency) or "4" (newborn) on all emergency inpatient and outpatient claims.

All other Admit Types, including a "2" for urgent, designate the claim as non-emergent.

On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.

Division staff will review ADA 2006 dental claims for adults to determine if the service provided was emergent.

Note: Adults are eligible for limited emergency dental services only. (Refer to Chapter 7 Dental for coverage limitations.)

Recoupment

A.R.S. § 36-2903.01 (L) requires the Division to conduct post-payment review of all claims and recoup any monies erroneously paid.

Under certain circumstances, the Division may find it necessary to recoup or take back money previously paid to a provider.

Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

Upon completion of the recoupment, the Remittance Advice will detail the action taken.

If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), the provider will be afforded additional time to provide justification for repayment as outlined below.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.

In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

- 12 months from the date of service, or
- 12 months from the date of eligibility posting for a retro-eligibility claim, or
- 60 days from the date of the adverse action.

If recoupment is initiated by the AHCCCS OIG as a result of identified misrepresentation, the provider will not be afforded additional time to resubmit a clean claim.

Additional Billing Rules

Do not submit double-sided multiple-page claims. Each claim page must be on a separate piece of paper with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3).

To ensure that all pages of a multiple-page UB-04 claim are processed as a single claim the pages should be numbered (e.g., 1 of 3, 2 of 3, 3 of 3). All pages should be clipped or rubber-banded together (do not staple). Totals should not be carried forward onto each page. The "001" total should be entered on the last page only.

The Division will key revenue and procedure codes billed with zero charges. However, revenue codes with zero charges will not be considered for reimbursement.

A. Mothers and Newborns

Newborns whose mothers are Division recipients are eligible for Medicaid services from the time of delivery.

Services for a newborn must be billed separately using the newborn's AHCCCS ID.

Services for the newborn that are included on the mother's claim will be denied.

B. Change in Recipient Eligibility

If the recipient is ineligible for any portion of a service span, those periods should not be billed to the Division.

If a recipient's eligibility changes each eligible period should be billed separately to avoid processing delays.

C. Change in Reimbursement Rate

1. It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.

2. When a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rate the claim must be split.

Documentation Requirements

Medical review is a function of the Division's Health Care Services Department and is performed to determine if services are provided according to Division policy related to medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided.

In order for this medical review to take place, providers may be asked to submit additional documentation for FFS CMS 1500 claims identified in the Division claims processing system as near duplicate claims. The documentation is necessary to allow Division Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, same day, same recipient, and different providers.

Near duplicate claims for certain E&M codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, Medical Review staff will release the claim for payment, assuming that the claim has not failed any other edits.

If no medical documentation is submitted, Medical Review staff will deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with Medical Review denial code "MD008 - Resubmit with progress notes." Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near duplicate edit because it is feasible that a recipient could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill the Division for CPT Code 90491 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

Note: The Division requires all claims related to hysterectomy and sterilization procedures be submitted with the respective consent forms. See Chapter 8, Maternity and Family Planning for specific information in the respective sections Hysterectomy and Family Planning.

While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to the Division are subject to Medical Review.

CMS 1500 Claims		
Billing For	Documents Required	Comments
Surgical procedures	History and physical, operative report	
Missed abortion/ Incomplete abortion procedures (all CPT codes)	History and physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-04 Claims		
Billing for	Documents Required	Comments
Observation	Refer to Division policy or AHCCCS FFS Chapter 11 Hospital Services for required	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, pathology report	Information must substantiate fetal demise

NICU/ICU tier claims with discharge date prior to 10/01/2014	Refer to Division policy or AHCCCS FFS Chapter 11 Hospital Services for required documentation with discharge date prior to 10/01/2014.	MD orders and MD progress notes to substantiate level of care billed
Outlier	Refer to Division policy or AHCCCS FFS Chapter 11 and 11 Addendum for required documentation	

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray films
- Medifax information
- Nursing care plans
- Medication administration records (MAR)
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays •
- Entire medical records.

Cost Sharing

This section define the Division's cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this section is also to maximize cost avoidance efforts by the Division and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

A. Definitions

1. Cost Sharing - The Division's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.
2. Dual Eligible Medicare Beneficiaries (Duals) - A Division member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+)
3. Full Benefit Dual Eligible (FBDE) - A Division member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.
4. In-Network Provider - A provider that is contracted with the Division to provide services.
5. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include, Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).
6. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.
7. Medicare Part B - Coverage for medically-necessary services like doctors' services, outpatient care, home health services, and other medical services.
8. Medicare Part D - Medicare prescription drug coverage.
9. Non-qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in A.A.C. R9-29-101.
10. Out of Network Provider - A provider that is neither contracted with nor authorized by the Division to provide services to its members.
11. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.
12. Qualified Medicare Beneficiary Only (QMB Only) - A person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.
13. Specified Low Income Medicare Beneficiary (SLMB) - Persons entitled to

Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary's Part B premium costs.

14. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

B. For QMB Duals and Non-QMB Duals, the Division's cost sharing payment responsibilities are dependent upon various factors:

- Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid
- Whether the services are received in or out of network (The Division only has responsibility to make payments to AHCCCS registered providers)
- Whether the services are emergency services, and/or
- Whether the Division refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. Title 9, Chapter 29, Article 3.

An exception to the Division's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the Division must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Division has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For the Division responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division Provider Manual, Chapter 57 - Third Party Liability.

A. QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their Division Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C.R9-22-2 or A.A.C. R9-28-2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

Division Payment Responsibilities

1. The Division is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this Policy. See also DDD Provider Policy Manual, Chapter 4 - Covered and Non-Covered Services. These services include:

- a. Chiropractic services for adults,
 - b. Outpatient occupational and speech therapy coverage for adults,
 - c. Orthotic devices for adults,
 - d. Cochlear implants for adults,
 - e. Services by a podiatrist, and
 - f. Any services covered by or added to the Medicare program not covered by Medicaid.
2. The Division is prohibited from using the 09 coverage code to deny payment for medically necessary services to members who are both Medicare and Medicaid eligible. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and Medicaid, and shall not be used to deny payment of claims.
3. The Division only has responsibility to make payments to AHCCCS registered providers.
4. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the Division's network or prior authorization has been obtained.
5. The Division must have no cost sharing obligation if the Medicare payment exceeds the Division's contracted rate for the services. The Division's liability for cost sharing plus the amount of Medicare's payment must not exceed DDD's contracted rate for the service. There is no cost sharing obligation if the Division has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the Division must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if DDD has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.
6. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST PAY: <i>(Subject to the limits outlined in this Policy)</i>
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: a. The Medicare copay, coinsurance or deductible, or b. The difference between the Division's contracted rate and the Medicare paid amount.

FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES
Services are covered by both Medicare and Medicaid
Subject to the limits outlined in this Policy

	EXAMPLE 1 (b. In Table 1 above)	EXAMPLE 2 (b. In Table 1 above)	EXAMPLE 3 (b. In Table 1 above)
Provider charges	\$125	\$125	\$125
Medicare rate for service	\$100	\$100	\$100
Medicaid rate for Medicare service (The Division's contracted rate)	\$100	\$90	\$90
Medicare deductible	\$0	\$0	\$40
Medicare paid amount (80% of Medicare rate less deductible)	\$80	\$80	\$40
Medicare coinsurance (20% of Medicare rate)	\$20	\$20	\$20
THE DIVISION PAYS	\$20	\$10	\$50

B. Non-QMB Duals

A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9, 9 A.A.C. 28, Article 2 from a provider within the Division's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22, Article 2. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

1. Division Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-2, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST <u>NOT</u> PAY:
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST PAY: <i>Subject to the limits outlined in this Policy</i>
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): a. The Medicare copay, coinsurance or deductible, or b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (The Division's contracted rate).

2. Division Payment Responsibilities (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracted provider the following applies (Table 3):

Table 3 NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION <i>Subject to the limits outlined in this Policy</i>
Medicare Only	Has no responsibility for payment.
Medicaid only and the Division has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Division has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay the lesser of: a. The Medicare copay, coinsurance or deductible, or b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

C. Prior Authorization

The Division can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Division is responsible for Medicare cost sharing if the member is a QMB dual, even if the Division determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Division must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Division must cover the cost of the service for QMB Duals.

D. Part D Covered Drugs

For QMB and Non-QMB Duals, Federal and State laws prohibit the use of Medicaid monies to pay for cost sharing of Medicare Part D medications.

E. Institutional Status Reporting – Part D Copays

Acute – When a dual eligible member is inpatient in a medical institution or nursing facility and that stay is funded by Medicaid for a full calendar month, the dual eligible

person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. (See Chapter 16b, Section 80.4.3 of the Medicare Managed Care Manual and Medicare Prescription Drug Benefit Manual, Chapter 13, Section